A Model Community-Based Residential Treatment Program

James Mackin Walsh
Sweetser Children's Home, Saco, Maine

ABSTRACT: A community-based residential treatment program for emotionally/behaviorally handicapped children is described as a model of normalization principles and practice. The operational effectiveness of community-based treatment is stressed in light of recent articles focusing on administrative obstacles to the implementation of a human service policy based on the normalization principle.

In light of recent debate (Gerber, 1981; Sabatino, 1981; Semmel & Morrissey, 1981; Shell, 1981) regarding the practical application of community-based treatment and educational programming for the severely handicapped, this article describes a model community-based treatment program based firmly on normalization principles. This description can serve as an example of how the letter and spirit of normalization can be made operational for even the most severely handicapped client. Emphasis will be made to highlight organizational and programmatic characteristics which were felt to be critical in enabling normalization principles to be realized. Criteria detailed by Wolfensberger (1972) and supported throughout the literature (Nirje, 1970; Ross, 1970; Thurman, 1979; Burish, 1979), as basic characteristics of deinstitutionalized treatment will be used to illustrate the normalized nature of this model treatment program.

Program Description

Amity/FAC was established in July 1978, in Auburn, Maine, in response to the need for alternatives to institutionalization for severely emotionally and behaviorally handicapped children and youth. With the expressed purpose of providing a working example of the deinstitutionalization of services for special need children, Amity/FAC quickly became recognized as a "model program for community-based treatment agencies" (Family Advocacy Council, 1979). Its program description asserts that children and their families are best served within the context of their own communities and that long-term institutionalization, isolation from the community and family,

Requests for reprints should be sent to James M. Walsh, 1288 High Street, Bath, ME 04530.

Child Care Quarterly, 14(1), Spring 1985

and separation from the mainstream of life do not allow children to grow to their full potential (Sammons, 1978).

As a residential treatment program based on a Browndale treatment process (Brown, 1976), FAC believed that throughout time the family has been the social unit that has best and most consistently met the needs of the individual. Therefore, a return of the child to his or her family and community with the necessary support for success was the program's primary objective. Amity/FAC further asserted that all handicapped, regardless of the severity of their emotional or behavioral handicaps, have the right to grow and learn in their own community. Thus, no referrals to FAC were rejected and each child and family received an unconditional commitment despite the degree of resistance or difficulties involved in service delivery. In order to live up to this principle of nonrejection, a variety of living and support arrangements were developed.

According to Wolfensberger (1972), "The normalization principle suggests or even dictates that group residential services have certain gross characteristics, among these being integration, smallness, separation of the domiciliary function, specialization and continuity" (p. 81). Amity/FAC program will be examined in light of these characteristics.

Integration demands that "residential services, like all services, generally need to be community-integrated and dispersed so that residents will intermingle with typical citizens in typical activities" (p. 81). Amity/FAC residential services consisted of a continuum of living arrangements depending on the treatment needs of the client, the most restrictive of which was a therapeutic family home placement. All residential services including therapeutic family homes were based in neighborhood community setting within easy access to major community service and recreational resources. Participation in neighborhood and community activities by each residence acting as a family unit was promoted and emphasized. Thus, involvement in such normal integrating daily activities as shopping, travel, eating in local restaurants, recreating at local parks, athletic facilities and movie houses, as well as inclusion in local school and youth programming was a purposeful part of treatment planning.

"Large facilities result in inward rather than outward direction of both resident and staff socialization and therefore they foster insulation from society, institutionalization of attitudes and behavior and often result in longer duration of stay of residents" (p. 81). In addition to avoiding the further institutionalization effects, smallness in residential services for the emotionally and behaviorally handicapped

child is particularly critical to overcome previous accumulation of years of deprivation and rejection. Shared among the original 44 youngsters at Amity/FAC were 150 years of institutional life and 300 different residences in their lives (Corbett & Walsh, 1982, p. 15). The infusion of an intense level of nurturance and care within a normalized family/community setting was an essential component of Amity/FAC's treatment program. Moreover, therapeutic family homes were established with no more than four children in them so that each child could receive the high degree of attention needed and so that the residence could indeed function as a family and not as a mini-institution.

"A major residential corollary of normalization is the separation of the domiciliary function" (Wolfensberger, 1972, p. 82). It is denormalizing and counterproductive to the goal of preparation for community living to offer every aspect of one's life within the confines of one building or compound. It may be convenient, but a deinstitutionalized child or youth must learn and in the long term will benefit more from seeking educational, medical, vocational and recreational services from regular community resources.

Amity/FAC therapeutic family homes were maintained strictly as a domiciliary functions with a deliberate attempt to utilize the community resources for other life needs. If at all possible, children were placed in public school programs, if not full time, then at least on a partial mainstreaming basis. Amity/FAC provided its own school in a separate location for those students who could not be serviced in the public setting. Only those remedial and special educational services which were not available from local resources were offered in the Amity School program. Thus, the community pool and gymnasium were utilized for physical education needs, the local library and educational resource center were used for educational materials, and the town parks, entertainment facilities, bowling alleys were used as recreational resources.

Medical, dental, and clinical treatment were obtained through local professionals and clinics offering community-wide services. For older youth with vocational or occupational needs, publicly sponsored work training programs were utilized if possible with Amity/FAC providing the necessary liaison and support for success. If involvement in a public work training program or placement in competitive employment was not possible, Amity/FAC provided a community-based work experience subsidized by Amity/FAC and supervised by staff to the degree necessary for the growth and development of more independent work skill. "Separation of the domiciliary function is one more expression of the management concept that human services

should not provide more support and shelter than a client needs" (p. 82).

To prevent a denormalizing situation of "protective overkill" in which residents with less need for structure and supervision would be denied a more normal existence because of being housed with more disabled or handicapped residents, Wolfensberger (1972) suggests that specialization in residential management has more normalizing features. Specialization, in this instance, is a recommended management response to potential unneeded supervision and detention for more advanced residents.

Heterogeneous grouping within a domicile, on the other hand has certain obvious normalizing characteristics which Amity/FAC therapeutic family homes attempted to promote. That is, because treatment was so firmly based on establishing a family environment and fostering a normal family lifestyle, each therapeutic family home was deliberately made up of boys and girls with varying diagnoses and ages. "We establish our homes in this manner to prevent the type of contamination that occurs in a milieu where youngsters have similar problem areas. People of varying backgrounds and behaviors have a great deal to give to one another, if provided with an opportunity that sanctions their interaction" (Corbett & Walsh, 1982, p. 16). The undesirable effects of heterogeneity, particularly "protective overkill" mentioned by Wolfensberger (1972) were minimized by a policy not to house more than one autistic or severely behaviorally disordered youth in any one residence and to individualized programming within each therapeutic family home.

"A continuum of living facilities will provide many more options than exist now, so that individuals can be moved along the continuum of supervision as needed, and in either direction" (p. 84). Program continuity, a range of residential and educational services from most restrictive/most supportive to least restrictive/least supportive, is a critical feature of a residential treatment center. A child must be able to grow and move from one level of treatment needs to another without having to make total breaks with established relationships.

The most restrictive residential care at Amity/FAC was a therapeutic family home with three or four residents under the direction of nonprofessional therapeutic parents and child care workers who were selected on their ability to establish a normal family environment and to normalize the life style of the participating children. The home had a great deal of programmatic autonomy and operated as closely as possible to the way a normal family in an open community would function (Corbett & Walsh, 1982, p. 16). The house parents received a

weekly stipend to operate their home. Budgeting for groceries, clothing, transportation, entertainment, etc., were carried out as a family. The full range of professional care needs are available within the community. Professional staff monitor house activities and write weekly evaluation reports as a basis for administrative accountability to clinical and program directors. An awake night staff work in the home from 10 P.M. to 8 A.M., assisting with household chores, checking on children during sleep and intervening with those who experience difficulty during that time.

> The therapeutic parents and child care workers of the therapeutic family home, wherever possible, work intensively with the family of the children under their care. Their objective is to extend the warm, human, health oriented approach that they have toward the children in treatment, to their families in the community. On a regular basis, visits are arranged and activities planned with the natural family. (Sammons, 1978)

Although most children begin their treatment in a therapeutic family home, those who do not need that level of restrictiveness may start at the next level on the continuum of services—a therapeutic foster home. Amity Project/FAC in conjunction with local Department of Human Service licensing offices established a range of community-based foster homes to provide care of one or two children in a normalized family setting. Foster parents receive training in the Browndale treatment process and are required to participate in weekly training sessions. Supervision and support from Amity/FAC family workers familiar with the child and his treatment plan is available on a 24-hour-a-day basis. The expectation is that while not replacing parents, the foster home will provide a temporary experience with a healthy family in which a child can learn normal family routine, expectations, accountability, and self control so that he may eventually move back into his own home with new skills and a successful and rewarding family experience.

The third level on the treatment continuum is a Family Outreach service which attempts to provide the alternative of in-home supportive services for the family whose child might otherwise have to enter residential or institutional care, or for the family whose child is returning home from a therapeutic family or foster home. The Family Outreach Program, suggestive of the notion that a bad home is better than a good institution (Bowlby, 1966), provides the services of the therapeutic family home to the individual in his natural home. "We strongly feel that all of our work with a child must be done within the orientation that the biological parents and the child's extended family

have more to offer the child than our most carefully laid plans can offer him" (Brown, 1976).

With this Browndale premise in mind and the belief that all parents want to be good parents, the Family Outreach Program attempts to provide the support and training needed by all members of the family to make it a more successful and positive environment for all its members.

> Staff work with the family in the home and community emphasizing the day to day child care processes that often break down in the home of an emotionally disturbed family. Family workers assist with wake-ups, meals, shopping, budgeting, tutoring, etc., trying to provide the concrete extended family type support that will allow the family unit to remain intact. In addition, the worker assists the family in making appropriate use of community services and serves as a spokesman for the family when the need arises. Support staff work closely with professional monitors to assure the development of a plan of in home intervention that is individualized to the special and unique nature of each family system. (Corbett & Walsh, 1982, p. 17)

The final level on the continuum of treatment services is the Supervised Independent Living Program.

> This program is geared toward the older adolescent who has grown out of the need for a family or home milieu and is in need of supportive community link up services that will promote independent community living. This program often serves as a logical follow up for residential or institutional placement for the 16 to 19 year-old offender who is in need of concrete services such as job placement, vocational training, GED preparation and other services that will contribute to independent functioning. Each youngster has a staff person who helps him find a suitable residence, locate job training programs, utilize community resources and establish counseling when necessary. A youth in independent living may live alone or with a one-on-one mentor depending on his needs. Older autistic like adolescents and physically handicapped youth may need a living partner on a long term basis. Expectations of these one-on-one includes in-house training in ADL skills, exposure to community life and experiences, regular contact with family and participation in treatment planning and training sessions. (Corbett & Walsh, 1982, p. 17)

Concluding Comments

Using Wolfensberger's (1972) five corollaries of normalization—integration, smallness, separation of the domiciliary function, specialization, and continuity—the Amity/FAC residential treatment clearly exhibits a high degree of compliance with the normalization

principle. Moreover, Amity/FAC's emphasis on treating the child in the context of his family and community has long been supported as an essential aspect of effective programming for the emotionally and behaviorally handicapped child (Bowlby, 1966; Hobbs, 1975; Lewis, 1982; Rhodes & Tracey, 1974).

Hobbs (1975) in making recommendations for the Project on Classification of Exceptional Children points out that "policy makers and professional practitioners have neglected or given casual or passing attention to the vital child rearing roles of families especially and of schools, churches and neighborhoods" (p. 223). Their recommendation that the normal social units responsible for child rearing must be reinforced to increase their effectiveness and that special agencies should be employed "only to the extent necessary to supplement the efforts of family, neighborhood and regular school" (p. 224) is reflected in the treatment philosophy and practice of Amity/FAC.

The effectiveness of community-based treatment, particularly in the treatment of the emotionally disturbed child, has recently been documented by Lewis (1982; 1984) who conducted both a review of the follow-up studies of children and adolescents who had been in residential treatment and a pilot study of a residential treatment center with an explicit commitment to ecological planning as part of its treatment effort. His review found that "programs with an explicit commitment to parental involvement during and after treatment and careful liaison with schools and community agencies do consistently report high rates of success on follow-up" (p. 151). His pilot investigation further supported and expanded this conclusion and indicated that "ecological support is essential to maintaining personal gains made by children during residential treatment" (p. 154). This high degree of success related to normalization principles put into practice was also evidenced by an Amity/FAC follow-up of children and youth discharged to family and community living.

This description of a community based treatment program for severely handicapped children has been offered as evidence of normalization principles successfully put into practice. The operational effectiveness of community based treatment has been stressed to contradict recent concern regarding the practicality of a human service policy based on normalization principles. It is hoped that future debate concerning the shift to deinstitutionalized community based care and treatment will be based on real as opposed to potential problems. Indeed, treatment programs for even the most severely handicapped can be community based and still offer a continuum of treatment services consistent with principles of normalization.

References

Bowlby, J. (1966). *Maternal care and mental health.* New York: Schocken Books.

Brown, J.L. (1976). The philosophy and rationale of the Browndale Treatment Process. *Family Involvement.* April, 7-13.

Burish, T.E. (1979). Small community model for developing normalizing alternatives to institutionalization. *Mental Retardation, 17* (2), 80-82.

Corbett, M., & Walsh, J. (1982). Death of a program. *Institutions etc., 5* (5), 14-19.

Family Advocacy Council. (1979). *Institutions, etc., 2* (2), p. 19.

Gerber, M.M., (1981). Economic consideration of "appropriate" education for exceptional children. *Exceptional Education Quarterly, 2* (2) 49-59.

Hobbs, N. (1975). *The futures of children.* San Francisco: Jossey-Bass Publishers.

Lewis, W.W. (1982). Ecological factors in successful residential treatment. *Behavioral Disorders, 7,* 149-156.

Lewis, W.W. (1984). Ecological change: A necessary condition for residential treatment. *Child Care Quarterly,* 13, 21-29.

Nirje, B. (1970). The normalization principles: Implications and comments. *Journal of Mental Subnormality, 16,* 62-70.

Rhodes, W.D. & Tracy, M.L. (1974). *A study of child variance* (Vol. 2). Ann Arbor: The University of Michigan Press.

Ross, P. (1970). Normalization, de-humanization, and conditioning: Conflict or harming? *Mental Retardation, 8* (4), 12-14.

Sabatino, D.A. (1981). Are appropriate educational programs operationally achievable under mandated promises of PL 94-142? *Journal of Special Education, 15,* 9-23.

Sammons, R. (1978). *Family Advocacy Council Program Description.* FAC Training Manual, Auburn, Maine.

Semmel, D.S. & Morrissey, P.A. (1981). Serving the unserved and underserved: Can the mandate be extended in an era of limitation? *Exceptional Education Quarterly, 2* (2), 17-27.

Shell, P.M. (1981). Straining the system: Serving low-incidence handicapped children in an urban school system. *Exceptional Education Quarterly, 2* (2), 1-11.

Thurman, S.K. (1979). Perspectives on normalization. *Journal of Special Education, 13* (13), 339-346.

Wolfensberger, W. (1972). *The principle of normalization in human services.* Toronto: National Institute on Mental Retardation.